

**EMS COUNTY GRANT APPLICATION**

**FLORIDA DEPARTMENT OF HEALTH  
Emergency Medical Services Program  
Complete all items**

<b>ID. Code</b> (The State EMS Program will assign the ID Code – leave this blank) _____	
<b>1. County Name:</b>	<b>Alachua County</b>
<b>Business Address:</b>	<b>911 SE 5th Street Gainesville, FL 32601</b>
<b>Telephone:</b>	<b>352-384-3101</b>
<b>Federal Tax ID Number (Nine Digit Number):</b>	<b>VF 59-6000501</b>
<b>2. Certification:</b> (The applicant signatory who has authority to sign contracts, grants, and other legal documents for the county) I certify that all information and data in this EMS county grant application and its attachments are true and correct. My signature acknowledges and assures that the county shall comply fully with the conditions outlined in the Florida EMS County Grant Application.	
<b>Signature:</b>	<i>Marahelen Wheeler</i> <span style="float: right;"><b>Date:</b> 12/14/21</span>
<b>Printed Name:</b>	<i>Marahelen Wheeler</i>
<b>Position Title:</b>	<b>Commission Chair</b>
<b>3. Contact Person:</b> (The individual with direct knowledge of the project on a day-to-day basis and has responsibility for the implementation of the grant activities. This person is authorized to sign project reports and may request project changes. The signer and the contact person may be the same.)	
<b>Name:</b>	<b>Michael D. Cowart</b>
<b>Position Title:</b>	<b>Assistant Chief - EMS Branch</b>
<b>Address:</b>	<b>911 SE 5th Street Gainesville, FL 32601</b>
<b>Telephone:</b>	<b>352-384-3117</b>
<b>Fax Number:</b>	<b>352-337-6138</b>
<b>Email Address:</b>	<b>mcowart@alachuacounty.us</b>
<b>4. Resolution:</b> Attach a resolution from the Board of County Commissioners certifying the grant funds will improve and expand the county pre-hospital EMS system and will not be used to supplant current levels of county expenditures. We <u>cannot process</u> for funds without this resolution.	
<b>5. Organization List:</b> Complete a budget page(s) for each organization, which at your option you will provide funds. List the organization(s) below. (Use additional pages if necessary)	
<b>Alachua County Fire Rescue</b>	
<b>North Central Florida Trauma Agency</b>	

For each position title, provide the amount of salary per hour, FICA per hour, other fringe benefits, and the total number of hours.	Amount
TOTAL Salaries =	\$ 0.00
TOTAL FICA & Other Benefits =	
Total Salaries & Benefits =	\$ 0.00

[illegible]

List the item and, if applicable, the quantity	Amount
Iron Duck ALS Backpacks	\$5824.00
Thomas Patient Life Straps	\$1830.50
Baltimore Airway Course	\$10,500.00
Critical Care Paramedic Course	\$5600.00
Medication Refrigerators	\$11,893.00
<b>Total Vehicles &amp; Equipment =</b>	<b>\$ 35,647.50</b>
<b><u>Grand Total =</u></b>	<b><u>\$ 35,647.50</u></b>



**FLORIDA DEPARTMENT OF HEALTH  
EMERGENCY MEDICAL SERVICES (EMS) GRANT UNIT**

## REQUEST FOR GRANT FUND DISTRIBUTION

In accordance with the provisions of section 401.113(2) (a), *Florida Statutes*, the undersigned hereby requests an EMS grant fund distribution for the improvement and expansion of pre-hospital EMS.

**DOH Remit Payment To:**

The county name, address, and corresponding federal ID number must be in the state MyFloridaMarketPlace (MFMP) system. A finance person in your organization who does business with the state must provide these.

Name of County: Alachua County

Mailing Address: 911 SE 5th Street  
Gainesville, FL 32601

Federal 9-digit Identification number: 59-6000501 3-digit seq. code

Authorized County Official: *Marithelen Wheeler* 12/14/21  
Signature Date

Marithelen Wheeler, Commission Chair  
Type or Print Name and Title

*Sign and return this page with your application to:*

*Florida Department of Health  
Emergency Medical Services Unit, Grants  
4052 Bald Cypress Way, Bin A-22  
Tallahassee, Florida 32399-1722*

Approved as to Form  
DocuSigned by:  
*Robert C. Swain*  
274EC3504E9336  
Alachua County  
Attorney

Do not write below this line. For use by State Emergency Medical Services Section

Grant Amount for State to Pay: \$ \_\_\_\_\_ Grant ID: Code: \_\_\_\_\_

Approved By: \_\_\_\_\_  
Signature of State EMS Unit Supervisor Date

Approved By: \_\_\_\_\_  
Signature of Contract Manager Date

State Fiscal Year: 2021 - 2022

<u>Organization Code</u>	<u>E.O.</u>	<u>OCA</u>	<u>Object Code</u>	<u>Category</u>
64-61-70-30-000	05	SF005	751000	059998

Federal Tax ID: VF \_\_\_\_\_ Seq. Code: \_\_\_\_\_

Grant Beginning Date: \_\_\_\_\_ Grant Ending Date: \_\_\_\_\_